Article

Progress on the introduction of supervisory ward manager roles since the Francis report recommendations

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Progress on supervisory ward manager recommendaton post Francis Report and Compassion in Practice: Lessons learned

Abstract

Recommendation 195 of the *Francis Report* suggested the introduction of supervisory ward managers into clinical practice could improve the quality of patient care in England. The phrase "lessons learned" was used rhetorically in the *Francis Report* (2013a, p. 11) and promisingly the Department of Health vision and strategy entitled *Compassion in Practice* (DH, 2012a) re-stated the recommendation in action area four with Trusts required to publish progress. With the aim of identifying "lessons (had been) learned" a review of the published literature since 2012 retrieved ony six papers on the subject with many anecdotal accounts of its implementation in local Trusts. The three subsequent update reports of *Compassion in Pratice* (DH, 2012a) stopped backing recommendation 195 and promoted black and ethnic minority leadership, a laudable initiative, but not a recommendation of the *Francis Report*. We suggest recommendation 195 and *Compassion in Practice's* original action area four should be promoted again to ensure public safety and address the notion that lessons learned are less likely to be repeated.

Introduction

In 2010 the Secretary of State for Health, the Rt Hon Andrew Lansley MP announced in the House of Commons, a public inquiry into the events of the Mid Staffordshire Inquiry (2013a; 2013b; 2013c; 2013d) referred to as the *Francis Report*. Systematic failings, neglect, bullying and poor quality of care and leadership within the Trust were found. In particular, the Secretary of State suggested it was not only a failing of the Trust, but a national failing "…*of the regulatory and supervisory system…*" (section 12, 2013a, p. 9) and he questioned why the failings at the Trust had only surfaced due to the determined action of families to expose failings. The *Francis Report* (2013a) summary identified 290 recommendations, and one of

those recommendations, 195 (see figure 1 entitled *Recommendations from the Francis Inquiry*, 2013a), suggested that nurse leadership could be improved if ward and nurse managers worked in a supervisory capacity, were not office bound and involved in supervising patient care plans whilst not being rostered (supernumerary) to care (p. 76). Other recommendations (see figure 1) suggested giving nurses recognition for their commitment to patient care and acquiring leadership skills (recommendation 196) and commissioning arrangements to ensure leadership training is available (recommendation 197) from students to Directors. There is criticism however, that *Francis Report* recommendations, such as increasing staffing levels on wards, are only implemented when they do not have resource implications for Trusts (Mahoney, 2014) due to a false economy perspective (Regan & Ball, 2017). The past can teach contemporary nursing much with regards to improving the standards of quaity care.

Historical elements of supervisory management

The notion of a supervisory nurse leader is not new and is attributed to the work of Florence Nightingale between 1860 and 1890 and her supporters (Wildman & Hewison, 2009; McDonald, 2014). The role of the matron required a trained nurse, an experienced ward sister and assistant matron, who could supervise the nursing of the sick and exercise greater control over nursing care (McDonald, 2014). Wildman and Hewison (2009) suggest the matron's prominance as a supervisory force changed in the 1960's when the *Salmon Report* (Ministry of Health, 1966) suggested the National Health Service (NHS) change to an industrial model; first line managers being the ward sister, nursing officers as middle managers co-ordinating a group of wards and top managers managing hospitals (Wildman & Hewison, 2009). The role of the nursing officer acquired the matron's role and the expansion of management science post *Griffiths Report* (DHSS, 1983) meant the nursing officer became largely administrative and non supervisory (Wildman & Hewison, 2009). The *Griffiths Report* (DHSS, 1983) advocated a system of general management and an end to professions' managing themselves

(Regan & Ball, 2017). Management science aimed to increase productivity, introduce cost savings and measuring nursing activities (Regan & Ball, 2017). This new business and measurement culture however, led critics to suggest nursing leadership was disempowered and unprecedented reports of NHS failings (Holme, 2015), such as the Parliamentary and Health Service Ombudsman *Care and Compassion* (Abraham, 2011), The *Mid-StaffordshireTrust Inquiry* (*Francis Report*, 2013a-d), and the *Morecambe Bay Investigation* [2015] (Regan & Ball, 2017). All reports apart from the latter refer to nursing in Trusts with non supervisory nurse leaders. The Morecambe Bay Investigation (2015) criticised supervisory midwives with conflicting dual management and supervision roles (Professional Standards Agency, 2016).

Re-introduced in the *NHS Plan* (DH, 2000), the modern matron's role depended on the employing Trust and followed three models: a direct clinical care role, simimar to the eard sister, a managerial role, similar to the previous nursing officers, or a mixed role, supernumary with a strong clinical role (Wildman & Hewison, 2009). The role of supervisory nurse manager came in the form of the modern matron, mentioned only once in the three volumes and one summary of the *Francis Report*. In *Francis Report* 1 (2013b, p.665) related to the Trust's Accident and Emergency department and reports of poor cleanliness, discharge planning, medicines management, staffing levels, communcation with patients relatives and carers, responses to complaints and a disorganised management of the department it briefly mentioned "…*facilitation of the appointment of clinical tutors to assist with service development until the arrival of the intended Modern Matrons*…" (p. 665). However, none of the three models of modern matron practice (clinical, managerial or mixed) was promoted over another (Wildman & Hewison, 2009). A key factor to improve the quality of nursing care in the *Francis Report* was the re-introduction of supervisory nursing leader (recommendation 195) at ward level. This recommendation was reinforced in action area four of the Department of Health's vision and strategy *Compassion in Practice* (2012a). This article aims to identify the

progress of recommendation 195 from the published literature and a lesson learned from the *Francis Report* (Mahoney, 2014).

Review of the literature

A review of peer reviewed literature from 2012 to 2018 was conducted in order to identify the success and implementation of recommendation 195. The search databases Cinahl complete, Cinahl Plus Fulltext, AMED, ERIC, Nursing Index, Medline, Psychinfo, PsychArticles were used. The inclusion criteria were peer-reviewed papers from England, and papers which were workforce centred and focussed on the role of the supervisory ward manager. The exclusion criteria to the retrieved literature was nursing management in general and international papers. The search terms “ward manager” and “supervisory,” both used in the *Francs Report* were identified published papers on the progress of supervisory ward managers in English Trusts. Six retrieved papers meting the inclusion criteria; the Royal College of Nursing (RCN) (2011), Duffin (2012), Snow (2012), Fenton and Phillips (2013), Kendall-Raynor (2013), and Regan and Shilitoe (2017), the latter a literature review on recommendation 195’s progress in the NHS. A review of NHS England’s website using the same search terms and dates retrieved no reports or papers on the subject, which were early indicators to the lack of progress of recommendation 195. Three key issues from the literature were identfied, two directly from the retrieved literature and the third as a result of a wider reading of the key documents in search of a rationale for the dearth of retrieved literature.

Three key issues

The first key issue is an inconsistent allocation of time for nurse leaders to be supernumary, with some Trusts allocating full time supervisory status and others between one to four days per week (Snow, 2012: Fenton & Phillips, 2013). The second key issue is the considerable quality improvements noted when supervisory ward manager and nursing leader status was

fully implemented (RCN, 2011; Duffin, 2012; Fenton & Phillips, 2013). The third key issue offers some explanation why supervisory ward managers or nursing leaders at ward level has been largely unsuccesful, anecdotal and unpublished (Regan & Shillitoe, 2017). We will discuss the two key issues from the retrieved literature before analysing the third.

Inconsistent allocation of time

The first key issue refers to an inconsistent allocation of time for nurse leaders. A survey of NHS organisations by Snow (2012) identified, from a survey by the Nursing Standard, that out of 50 NHS Trusts responding to the survey, ony ten had implemented supernumary ward management fully, and out of the remaining 40 Trusts, 37 had partial allocation and 3 not at all. In contrast ward managers in Central Manchester University Hospitals NHS Foundation Trust spent half their time being supernumary and the other half giving direct care (Duffin, 2012). Snow (2012) identified that some Trusts had implemented supervisory nursing leadership in England, such as; Macclesfield District General Hospital, Cheshire, Birmingham Heartlands Hospital, Penine Acute Hospitals Trust, North Manchester and Fairfield General Hospital, Royal Oldham Hospital, Rochdale Infirmary and lasty, Northern Lincolnshire and Goole Hospitals NHS Foundation Trust. The list is small therefore the implementation scale of recommendation 195 in English hospitals remains relatively unknown.

Quality improvements of supervisory status

The second key issue refers to the considerable quality improvements noted after the implementation of supervisory ward managers, or nursing leaders. Snow (2012) discussed the benefits of introducing supervisory ward sister roles at Macclesfield District General Hospital in Cheshire helped ward sisters to manage rather than be on the staffing rota, and as a result the health and well-being of staff improved through; timely staff appraisals, clinical audits, dealing with complaints and incidents. Duffin (2012) referred to the term “supernumary”

status and the ward manager not being counted in the staffing numbers. Duffin (2012) suggested there was a clear correlation of improved quality of care in Trusts where ward managers were fully supervisory, such as in Milton Keynes University Hospital NHS Foundation Trust, Buckinghamshire. In one respiratory ward, the ward manager was both supernumary and supervisory, giving them the time to teach directly; on customer care, how to address patients, organising training and developmental opportunities for staff, time to complete clinical audits, manage incidents and investigations into clinical matters (Duffin, 2012). The clinical benefits of implementing recommendation 195 were found to be; having time to give feedback to patients and relatives, attend to human resource issues such as sickness, absence, return to work interviews which were more effective in improving recruitment and retention of staff due to improved health and well-being of staff (Duffin, 2012). The clinical benefits helped to improve pain management leading to fewer complaints. Similarly, Fenton and Phillips (2013) identified that 40% of ward managers used their time to provide non-supervisory clinical leadership, and it was inapprpriate to expect nursing leaders could effectively combine clinical practice and effective ward management. This was despite RCN (2011) guidance suggesting it was false economy for ward managers to be included in staffing numbers and that quality leadership needed to be visible, accessible, monitor the quaity of care whilst working alongside staff. Supervisory ward managers had a positive impact on staff and patient satisfaction with a reduction in medication errors and staff sickness by creating a culture of learning, timely feedback and developing person centred care (RCN, 2011). We will now discuss the background to the third key issue.

Discussion

The dates of the retrieved literature indicate an early motivation for English Trusts to implement some of the *Francis Report* recommendations, despite criticism their implementation has been limited (Mahoney, 2014). Jane Cummings (Cummings, 2013), the Chief Nursing Officer for England and co-author of the *Compassion in Practice* vision and

strategy stated in “Supporting policy” (slide 5) that *Compassion in Practice* (DH, 2012a) was a vision and strategy and a response to reports of failings in the NHS such as the *Francis Report* and abuse at Winterbourne View (DH, 2012b). *Compassion in Practice* (DH, 2012a) introduced the succesful 6Cs; care, courage, competence, communication, commitment which were a re-statement of demonstrable caring qualities in everyday clinical practice. This was a key supporting vision and strategy to recommendation 195.

Compassion in Practice (DH, 2012a) identified six action areas which we will paraphrase: first, helping people to stay independent, maximise well-being and improve health outcomes, second, working with people to provide a positive exerience of care, third, delivering high quality care and measuring its impact, and fourth, the focus of this article, building and strenghtening leadership. The fifth action area was “ensuring …the right staff…the right skills in the right place…” and lastly, sixth, supporting positive staff experience. The six actions areas of *Compassion in Practice* (DH, 2012a) paralleled some of the *Francis Report* recommendations (see figure 1), and action area four (see figure 2 entitled *Building and strengthening leadership*) suggested local Trust providers review options for “…*introducing ward managers and team leaders’ supervisory status into their staffing structure*…” (p. 21) in order to give them “…*time to lead…*” (p. 22*)*. This is what could be called the “original” action area four in *Compassion in Practice* (DH, 2012a). More about that issue later. Action area four suggests “…*providers undertake a review of their organisational culture and publish the results*…” (DH, 2012, p. 28). This issue was considered to be important and repeated in action area five and “…*ward or community nurse /midwifery leaders are supervisory to give them time to lead. We hope this will be accepted and built into all future workforce tools…”* (p. 22). Therefore, the lack of published literature indicates a lack of progress of recommendation 195 and action area four (Regan & Shillitoe, 2017). The next section discusses possible reasons why.

Third key issue: Changed narrative and perspective

Compassion in Practice (DH, 2012a) cannot be viewed as a stand alone vision and strategy because there were three yearly updates planned between 2012 and 2015 (NHSE, 2012, 2014a; 2014b; Serrant, 2016). The parallels between the *Francis Report* recommendations (2013a, 195-197, seee figure 1) and *Compassion in Practice's* original action area four (see figure 2) were short lived. *Compassion in Practice* update reports (NHSE, 2012, 2014a; 2014b; Serrant, 2016) identified a shift in priorities away from the very specific recommendation 195. The *Compassion in Practice: Two years on* (NHSE, 2014a) update did not mention the "original" supervisory ward manager action area, instead the report identified four key areas for action; strengthening BAME leadership, developing skills to challenge poor practice, promoting a good business model through compassionate leadership and boards. The update reviewers stated they "…*held leadership think tanks*…" (NHSE, 2014a, p.33) to identify the four key action points to support commissioned research and recruitment to compassionate leadership programmes. The NHSE (2014a) update referred to progress such as leadership programmes and piloting of the *Care cultural baramoter* developed by Kings College London to provide a tool for organisations to measure the culture of care between staff and managers with an emphasis on compassion. Research had been commissioned to assess the impact of nurse/ midwifery leaders supervisory role on wards to provide safe, effective staffing levels and critical decision making (p. 44). However, a search of NHSE (2014a) using the word "supervisory" found reference to the role for nursing and midwifery leaders in action area five (ensuring the best level of care by demonstrating the right number of staff, the right skills and the right behaviour to meet the needs of people in their care, p. 41). Hence, the narrative of action area four changed to the promotion of black and minority ethnic (BAME) nurses in leadership poisitons. Nursing leadership was racialised (Serrant, 2016) in NHSE (2014b) entitled *Building and strengthening leadership: Leading with compassion Building and strengthening leadership: Leading with compassion. Compassion in Practice's* new agenda for action area four meant recommendation 195 mirrored in the "original" action area four

recommendation, had little chance of success nationally, demonstrated by the few publications retrieved since 2012, further evidence that key lessons had not been learned from the Francis Report.

A search of all three volumes of the *Francis Report*, summary (2013a-d) and the vision and strategy *Compassion in Practice* (2012a) using the terms “BAME” and “ethnicity” found little or no mention of an ethnicity issue. The first and second *Francis Report* (2013b; 2013c) mentioned ethnicity as a measurable criteria for hospital standard mortality rates and quality metrics, not as a care or leadership issue. So it was important to find the rationale for such a change. The reasons given in the update reports were an under representation of BAME leaders at executive level, suggesting this was important because one in five staff in the NHS are BAME (Serrant, 2016). The update reports also suggested BAME staff had experienced discrimination by a lack of training and recruitment (Priest et al, 2015). As a result, the NHS Leadership Academy specifically focused on BAME leadership in the *Next generation career acceleration* workshop in 2015, with a leadership programme supported by coaching, mentorship and career guidance (Serrant, 2016). This initiative also relates to NHS organisations now being assessed on indicators for ethnic diversity (Priest et al., 2015). To be clear, whilst promoting diversity and BAME leadership is of significance, it is not directed by any of the 290 recommendations from the *Francis Report*, which was one inspiration for *Compassion in Practice* (DH, 2102a) in the first place (Cummings, 2013).

Lessons learned

In relation to recommendation 195, the lessons learned,would have led to improved quality of care to patients in English Trusts. Wildman and Hewison (2009) suggest the change from supervisory and supernumary status of nursing leaders was due to wider policy changes. One policy change is the development of management secience in the NHS post *Griffiths Report* (1983). In the Kirkup report entitled the *Morecambe Bay Investigation* (2015), between 2004

to 2013 at Furness General Hospital (FGH), unsafe care related to; a need to save £24 million from the Trusts budget, poor staffing levels, increased workload pressures, performance management (section 1.82, p. 34), all contributing to clinical incompetence, deficient skills and knowledge, failures of risk assessment and care planning. Management failures were also noted in the *Francis Report* (2013a, p. 4) as determining factors to reduce standards of care. Notably at FGH there was repeated failure to properly investigate incidents or learn lessons from organisational and clinical mistakes. This systemic failure led to 21 serious untoward incidents, the deaths of three mothers, 16 babies and damning criticism of regulatory and supervisory investigative systems, again mirroring the findings of the *Francis Report* (2013a, section 12, p. 9). Confusion was noted in relation to the conflicting duality of managerial and supervisory roles, and conflicts of interest occurred due to supervisors of midwives having no formal links with governance, risk management or the risk manager was also a supervisor of midwives (3.46, p.57). Ethnicity of midwifery leadership was not mentioned as an issue.

Critically, lessons learned for Trusts appear to be relevant to professional regulatory bodies, which brings into question the culture of learning from mistakes within the nursing and midwifery profession. The Professional Standards Agency (PSA, 2018) report entitled *Lessons learned review* on FGH focused on the Nursing and Midwifery Council's (NMC) handling of allegations against midwives there. Concerns related to the quality of pre-2014 NMC investigations at FGH and the suitability of the fitness to practice system. The concerns included: poor communication with families, bereaved families experiencing distress at the handling of cases (length of time) or the full range of conduct of a registrant poorly investigated [clinical, collusion and honesty] (PSA, 2018). The PSA (2018) report identified the NMC had poor record keeping, poor; analysis or implications of case material, action or analysis of third-party information. Family information, which should have reduced their grieving and anxiety, was not taken seriously because the NMC adopted a defensive approach when criticised (PSA, 2018). The relevance of the PSA (2018) report and the aims of this article refer to the poor implementation of the *Francis Report* recommendations nationally (Mahoney, 2014),

even by the regulatory body for Nursing and Midwifery, the NMC (PSA, 2018). For example, the PSA (2018) noted that recommendation (139 to 141) of the *Francis Report*, namely the need for the NMC to establish a relationship with Trusts to communicate concerns about a registrant, giving the NMC intelligence on failing Trusts and sharing of information with other stakeholders and the Care Quality Commission, were only adopted in 2016 by the NMC in response to investigative findings of its handling of complaints against registrants.

In conclusion

This article had as its remit, the appraisal of *Francis Report* recommendation 195 due to criticism that any Trust implementation relied on not being a fiscal resource issue (Mahoney, 2014). We discussed the dearth of published papers and the findings from the literature identified three key issues; first, the inconsistent implementation of supervisory ward manager and nurse leader status in Trusts, second, there were proven qualty and cost savings noted when implemented into a Trust. What was difficult to understand was why Trusts's were given the choice in the *Francis Report* and *Compassion in Practice* to implement the necessary changes (recommendation 195) to improve quaity of care, when it had been cost saving exercises in the first place that had directly led staffing shortfalls, workload pressure and failings in the NHS (Regan & Ball, 2017). Recommendation 195 related to action area four of *Compassion in Practice* (DH, 212a), yet subsequent update reports did not comment why the narrative of the original action area four (DH, 2012a) had changed. A further search of the literature identified some possible reasons why; the promotion of BAME nursing leadership due to one in 5 nurses being BAME (Priest et al, 2015).

A regulatory issue compounding the implementation of the *Francis Reports* recommendations, apart from Trusts themselves (Mahoney, 2014) was criticism of the NMC handling of complaints leading to a recommendation from the *Francis Report* only being adopted in 2016. As the Rt Hon Andrew Lansley MP Secretary of State for Health stated in 2010, one Trust's failings reflects badly on all Trusts nationally, and any Trusts or organisations disinclined to

implement the *Francis Report* recommendations suggest not all lessons have been learnt, understood or new priorities emerge. Therefore, as reports of unprecedented failings in the NHS continue (Regan & ball, 2017), a lesson not learned is likely to be repeated.

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